WINDS OF CHANGE
MENTAL HEALTH CENTER

June, 27th 2019

Members of the Legislative Interim Committee on Child, Family, Health, and Human Services,

My name is Angelica Mothka and I am a Licensed Clinical Social Worker and a Certified Mental Health Professional by the Department of Health and Human Services. I am the clinical administrator at Winds of Change Mental Health Center in Missoula. We serve adults and children who suffer from mental health and substance use related disorders.

I will try to be brief, but I do have much to share with you. I want to begin by echoing much of what was said by Ms. Windecker in her statement by also relaying our gratitude and thanks to DPHHS and specifically the people who work tirelessly in the Addictive and Mental Disorders Division. I know they often advocate for us and they have a lot of constraints and pressure from a lot of different sides. As a manager I know that maintaining a budget is never an easy task, so I do want to thank them for all of the work that they have been doing to try to balance some very complex difficult problems. We appreciate them working with members of BAHM and other providers in the state in order to create a sustainable and effective targeted case management model and an overall sustainable behavioral health care system. I think that there have been many things that have gone right that we are thrilled to be able to start doing or changing such as the ability to offer intensive outpatient treatment for substance use disorder for the first time at our Agency.

We have two big concerns at our agency regarding policy and rate changes, Targeted Case Management and the Utilization Review Process. My understanding is that the targeted case management debate and concerns about it's effectiveness have been ongoing for quite some time and that people are concerned that it may be misused or not utilized effectively by agencies. My take on it having seen the difference over the last two years between clients with case management and people without case management, is that case management is effective and a linchpin service.

Effective and useful case management is case management that can be sustained by an agency because it's reimbursable at a rate high enough to pay its bachelors-level workers a market-value living wage. That kind of case management helps the effectiveness of all the other services and systems their clients are involved in. Case management is not considered a "direct service," which I think is where a lot of the debate and problems stems from. It's difficult or downright unethical to try to do an empirical study to quantitatively identify the importance and effectiveness of case management. Case management augments and coordinates every aspect of the various systems in their clients' lives. They work with their clients to get paperwork filed, to schedule appointments, to navigate the complicated labyrinth that exists in public welfare and social services. They do that in order to make their clients be able to achieve things that those clients may never even thought were possible.

I know the evidence is there to support the use of case management. I think that we can see it in our communities every day. Since case management is not a "direct service," we have to look at the outcomes of the systems that are impacted by it or impacted by the lack of case management such as homelessness rates, suicide rates, incarceration, children being placed in foster care, commitments to the state hospital, public health, and the economy.

Now I wish I had ironclad empirical studies to show you that targeted case management has better outcomes in Montana than for people who need it and don't have targeted case management. Unfortunately, I personally do not

have that right now. What I do have for you is stories, information, and my own perspective and observations as a professional and a native Montanan. The difference between 2017 and 2018 were drastic for our agency and for the community at large. Yesterday we received some statistics on detainments in Missoula County for Mental Health Related issues from January 2017 through to this last Tuesday. In 2017 the County Attorney's Office in Missoula received 241 petitions to involuntarily commit individuals due to mental health related reasons. In 2018 there's a nearly 25% increase where they saw 300 petitions to involuntarily commit individuals to the state hospital. Ultimately there were 50% more people committed to the state hospital in 2018 than in 2017. Based on my observations and experience, this was directly due to the budget cuts that we faced in 2018. After those cuts happened and many agencies closed their doors or abandoned case management all together, we started seeing more difficult and complex cases popping up, we started to see more addictions and homelessness, we started to see a ripple effect in the various systems that are touched by case management. We started to see clients from agencies that closed or cut case management suffering more and more. These people were abandoned by the systems that were supposed to help them. Social services are often a safety net that is supposed to be there for people if they need it, but many people started experiencing that safety net drop and fail them. Those of us in the field tried our best to put out all the fires we could and help keep people alive. Really I think we did a pretty good job of it all things considered. 2019 has been on track to be nearly what 2018 looked like, but it may be even worse with more reimbursement cuts.

2018 was rough. Many people in the field lost their jobs, had wages cut, left the field, or left the state. I believe many people, clients, unfortunately lost their lives or became very close to entirely ruining their lives and I would hazard a guess that the states lost hundreds of thousands of dollars if not more than a million dollars in increased costs from increased state hospital commitment, from increased necessary and unnecessary Emergency Department visits, from increased law enforcement overtime, from lost income tax revenue from people who might have been able to sustain a part-time or maybe even full-time job with the help of the case manager, lost revenue from workers who lost their jobs and maybe had to leave the state to find work in their field to a less volatile environment. All of those things resulted in immediate higher costs, the budget cuts of 2018 will likely also have a pervasive impact on Montana's revenue for years to come including helping to shoulder the cost of those whose health was worsened because they don't know how to make an appointment and keep an appointment to see a primary care provider and including the estimated costs of suicides and general deaths on a state's economy.

I think that these budget cuts cost the state of Montana far more money and lives than it ultimately saved. It may be difficult to see because the costs are spread out across systems and various budgets, but I will tell you that if you look, you will undoubtedly find it. I'm here today to tell you that when the new rate goes into effect next week for case management, agencies that did continue providing those services will be crippled and that may be the final nail and many of their coffins. It is not sustainable.

I am obviously not at all familiar with or knowledgeable about the budget that DPHHS and specifically AMDD has to operate within and I can't even imagine how difficult it is to juggle such a budget but I think that there are places that money is being unnecessarily spent that doesn't have to be. There is money being spent that is not going towards improving anyone's life, and is not going back into the Montana economy. There is money being spent that can go towards these very useful services. Specifically I'm talking about the money spent on contracting with Magellan Health to perform utilization reviews to determine if people are eligible for certain services such as Group Home Stays, Hospitalizations, Crisis Houses, Addiction Treatment, and even some Community-based services like PACT. Over the last year in addition to trying to manage the Case Management cuts and putting out all the fires everywhere we have had to allocate more than two and a half (2.5) full-time positions now to the utilization review process for 44 clients to enter into or remain in our 5 Missoula-based group homes.

The department has contracted with Magellan health care to determine the medical necessity of people being in the group homes. On a surface level it seems like a very useful good idea to make sure that people are not abusing the system, but as soon as you start looking deeper you find glaring flaws. For one, the state already pays people to determine medical necessity for various services. They pay the providers who initially assess, refer, and look over the

client's treatment. Magellan micro-manages care in a lot of ways. What ends up happening is my colleagues and myself spend copious amounts of time looking through records, interviewing clients, writing up the prior authorizations and continued stay reviews, and then we have to track them and keep all the records we sent because we can't trust things will not get "lost" or "stuck." We've lost tens of thousands of dollars of unpaid services provided between claims being "stuck" in the system and between small clerical errors on both our and Magellan's side. We bear the brunt of any mistakes or choices they make, they have no horse in the race and have no accountability that I'm aware of to ensure they are doing their best work that we supposedly pay them for.

But worse we've had a handful of clients who have had to leave the Group Home's because they've been denied for sometimes silly and ridiculous reasons like the reviewer does not like the medication somebody is on just because they are judging the services somebody is getting just by the words put on the paper without ever meeting or seeing the client. So it doesn't come down to how good or necessary the services actually are that the client is getting, it comes down to how good is the person who's writing the reviews at actually attempting to convey the services the person is getting.

We're now in the cycle where we see clients getting worse every 90 days just because they're not sure if they're going to be able to stay in the place that they call home for another 90 days. They don't know if they're going to be able to have somebody help them manage their medications or if they're going to have the support to make sure that they have somebody talk to if they're feeling suicidal or get very close to attempting suicide, or hurting others. We consistently see more and more clients having suicidal thoughts and worsening symptoms. The stress is impacting them so much we are seeing declines in their recovery and then are told that we're not doing enough to help them by Magellan. Every time they see one of their peers being "kicked out" of the group home there is sheer panic for weeks from nearly all of our 44 clients.

To give you a small glimpse into the issues we face we had one client last year whose case was accidentally reviewed by two Magellan reviewers at the same time and both sent it to the same doctor to review. That doctor then denied that person's stay for two completely unrelated reasons, one time the doctor did not think their symptoms were severe enough and the other time they claimed the client was suffering a substance use disorder which did not make him eligible for our group home. That client did not have a drinking or drug use problem in the slightest but he was denied for one. We ultimately put in an appeal, which is not an enjoyable process and it was overturned, but now that same person has to leave the group home because another doctor does not like the particular medication regimen the client is on.

Magellan has caused a cycle where our clients in the group home begin to get worse every 90 days waiting to know whether not their going to be able to stay in the Group Home rather than being able to work on their recovery. As a result it then takes longer for them to move out of the group home. The whole process puts their well-being at risk while wasting Montana dollars in more ways than one.

I think that the money that is being spent on Magellan is ultimately the wasteful spending that people are trying to prevent. I don't even have a clue how much it is but it can't be cheap. I can't imagine hours of doctors' time being cheap in addition to the cost of the reviewers, the managers, the overhead, and the time being spent by the department looking into these issues that we experience and report. The money spent on Magellan isn't really helping people and it's not saving the department money. Over the last year we've only had three people who've actually had to leave our group homes because in the end Magellan said that they did not think that they had met medical necessity and we then turn around and fill those spots right away because we have a long waiting list. I don't think money was saved.

I think that those funds can be reallocated to the things that we, at least by observation and experience, know work like targeted case management, like this substance use treatment, things like intensive outpatient treatment, and things like staffing in DPHHS' department itself.

Medicaid reimburses about $100 a day for a person to be in the Group Home that's less than many other services. That is significantly less than crisis house stays, specifically about a third the cost of one night in a crisis house. The group home rate is about an eighth of the cost of a state hospital daily rate and it's about one 20th of the cost of a day in hospital-based psych unit.

I don't know what the exact breakdown in percentages that Montana ends up spending on that $100 group home day since much of the Medicaid costs are reimbursed at the Federal level. But I can tell you that I'm confident it's less than the state is spending on these utilization reviews and paying Magellan. I think that we're not saving money and I think that they're costing us money. On top of all that, the money is leaving the state and going to a fortune 500 company from another state that profits off of states like ours and situations like ours. A company that was fired by Montana from managing the state's care twenty years ago, I might add.

I am sure the members of AMDD feel like they are stuck between a rock and a hard place and even harder place. So, if I had one specific proposal for you today in order to help with this very complex problem, one concrete and specific solution, it would be to stop the utilization review process on those lower levels of care like residential group home treatment and instead allocate that money towards the other services that do help Montanans. I know I'm not an expert when it comes to all of the things that the Department of Health and Human Services does manage and deals with on a daily basis. I don't know the slightest about the intricacies that go into their budget but I can tell you that mine is only one solution and I'm sure there are others as well.

I think that the department has shown that they are willing to work with us on these difficult things and I think that we can continue to work on them, but when this case management rate goes into effect next week it's going to hurt and there is a good chance you're going to see another crisis like what we saw in 2018.

Thank you once again, I am happy to answer and questions you might have for me.

Sincerely,

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